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Case Study

AYURVEDIC MANAGEMENT OF HIDRADENITIS SUPPURATIVA

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ABSTRACT

Hidradenitis Suppurativa (HS) could be agonizing skin condition that causes skin abscesses and scarring on the skin. It is one of the most distressing dermatological conditions which affects the person's life quality. Exact cause is unknown, but it occurs in areas rich in apocrine glands such as axilla, groin, peri anal, perineal and infra mammary area etc. This condition is having high psychosocial impact. In Ayurveda it can be considered under *Nadi vrana.* There are many *Chikitsa* principles are explained. Management of hidradenitis along with *Agadatantra* principles needs special attention. **Methods***:* Here we report a case of hidradenitis suppurativa having painful mucopurulent abscesses over both axilla and buttocks. *Sodhana* and *Visha chikitsa* principles were used for management of this condition. **Results**: Purulent discharge and foul smelling completely relieved and thickness of lesion got reduced. **Conclusion:** Management of skin lesions having chronic onset can be managed with principles of Ayurveda and *Visha chikitsa.*

INTRODUCTION

Hidradenitis Suppurativa (HS) is a long-lasting, inflammatory condition of the skin that results in recurring, painful nodules and abscesses that burst, leading to sinus tracts and scarring.[1] The lesions typically occur in areas of the body that have apocrine glands. HS generally manifests after the onset of puberty, with most cases beginning in a person's twenties or thirties, and is more common in females.[2] Reports of HS appearing after menopause are uncommon, though there have been isolated instances of the condition arising in prepubescent individuals undergoing premature adrenarche.[3] Because of its persistent nature and frequent flare-ups, HS significantly impacts the quality of life for patients, affecting their social interactions, work life, and mental well-being. Timely diagnosis is essential for individuals with HS to secure the most effective management of this challenging and uncomfortable condition while minimizing the number of sick days and healthcare visits associated with HS. However, HS diagnosis generally occurs after an average 7-year delay.[4] The primary defect in HS pathophysiology involves occlusion and subsequent inflammation of the hair follicle. The main flaw in the pathophysiology of HS relates to the blockage and subsequent inflammation of hair follicles; these issues, combined with both innate and adaptive immune system irregularities, play a crucial role in the onset of clinical HS.[5] Bacterial infections and colonization are deemed secondary harmful factors that can exacerbate HS. The blockage of hair follicles causes them to expand, eventually leading to a break, causing the contents of the follicle, including keratin and bacteria, to leak into the adjacent dermis and trigger a strong chemotactic reaction from neutrophils and lymphocytes. The accumulation of inflammatory cells triggers the development of abscesses, which results in the damage of the pilosebaceous unit and eventually harms nearby adnexal structures.[6] Several elements that could play a role in developing hidradenitis suppurativa (HS) include an altered production of antimicrobial peptides, irregular secretion from apocrine glands, abnormal skin invagination that leads to sinus tract formation, and a lack of sebaceous glands.[7] Typically, HS is found in areas of the body that possess apocrine glands, including the armpits, groin, anogenital regions, perineum, and the area beneath the breasts in women, although atypical lesions can also appear in the waist, abdomen- particularly around the belly button- and chest.[1] The locations affected by HS are not only associated with the presence of apocrine glands but also with terminal

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hair follicles that depend on lower levels of androgens.[8] In the early stages, HS is marked by the emergence of painful subcutaneous lumps that are often called "boils" or "pimples." Almost half of those affected experience symptoms such as a burning or stinging feeling, discomfort, itchiness, heat, or excessive sweating, 12 to 48 hours prior to the appearance of noticeable nodules.[9] The average lifespan of an individual painful nodule ranges from 7 to 15 days. Over time, these nodules can break open, leading to painful, deep dermal abscesses. Following rupture, the lesions frequently release a pus-filled, unpleasant-smelling fluid. With disease progression, draining sinus tracts, fibrosis, and scarring can be observed.[10] Diagnosis of HS is made by clinical observation, and a biopsy is rarely needed. HS can easily be differentiated from other diseases by the age of onset and by the characteristic locations of the lesions.[11] Here we report a case of hidradenitis suppurativa having 9 years of duration. *Sodhana* and *Visha chikitsa* principles were used for management.

Case Report

A 30-year-old male patient complained of several mucopurulent discharge abscesses in both the bilateral gluteal folds and the axillae, along with localized hardened regions. For the last nine years, he has been employed at a chicken stall. He gradually noticed painful erythematous induration across his right axilla. Mucopurulent discharge exacerbated other lesions, which continued to be an unhealed abscess. He experienced symptomatic alleviation after taking allopathic medicine. Similar lesions developed across the left axilla six months later. Even after taking antibiotics, nothing changed. He had surgery three years ago. Following that, the purulent flow decreased, but the lesions persisted. He experienced identical lesions across both gluteal folds four years later. He therefore sought advice at VPSV Ayurveda College Hospital for additional management.

Personal History

Appetite: Reduced
Bowel: Constipated
Micturition:6times/day
Sleep: Reduced
Allergy: Nil

Family History: Nothing relevant

Clinical Examination Findings

- Pallor: Absent
- Icterus: Absent
- Clubbing: Absent
- Cyanosis: Absent
- Lymphadenopathy: Present

Systemic Examination

CVS: s1s2 heard, no added sound. No abnormality detected.

RS: Normal breathing sound, no added sound heard.

GIT: Soft non tender, no organomegaly

CNS: Intact, orientation to time, place, person intact

Local Examination

Axillae

Inspection: Blackish discolouration of the area with 7-8 mucopurulent abscesses with opening.

Palpation: Slight rise in temperature with temperature and is having communicating sinuses in between.

Buttocks

Inspection: Blackish discolouration of the area with 10-15 mucopurulent abscesses with opening.

Palpation: Slight rise in temperature with temperature and is having communicating sinuses in between.

Treatment

Treatment was given at the IPD level.

Table 1: Treatment Schedule

S.No	Treatment	Medicines	Days
1	*Rookshana*	1) *Thakrapanam* with *Shaddharanam choornam* 2) *Kashaya dhara-sarvanaga* with *Patola mooladi kashaya*	4 days
2	*Snehapanam*	*Panchathikthaka ghritham*	5 days
3	*Abhyanga* and *Utklesana ahara*	*Dhanwantharam taila*	1 day
4	*Vamanam*	*Yashti phanta*	1 day
5	*Snehapanam*	*Panchathikthaka ghritham*	5 days
6	*Abhyanga*	*Dhanwantharam taila*	3 days
7	*Virechana*	*Avipathi choornam*	1 day
8	*Kashaya dhara*	*Kottam thakaradi kashayam*	7 days

Table 2: Assessment of major subjective symptoms during treatment

S.No	Before treatment	After treatment	Re-visit
1	Thickness of the lesion	+++	++
2.	Mucopurulent discharge	+++	-
3	Foul smelling	+++	-

Discharge Medicines

1) *Taruna bhaskaram gulika* (1 tab twice daily after food for 2 weeks)

2) *Kshalana* with *Kottam thakaradi Kashaya* (daily)

First Follow up

1) *Thriphala guggulu* (1-0-1)

2) *Gandhaka rasayana* tab (1-0-1)

3) *Manibhadra gula* 1 tsp at night after food

4) *Kottam thakaradi Kashaya kshalana* (daily)

Second visit

1) *Thriphala guggulu* (1-0-1)

2) *Gandhaka rasayana* tab (1-0-1)

3) *Manibhadra gula* 1 tsp at night after food

4) *Kottam thakaradi Kashaya Kshalana* (daily)

DISCUSSION

Hidradenitis suppurativa (HS) is a painful skin condition that causes skin abscesses and scarring on the skin. It is one of the most distressing dermatological conditions which affects the person's life quality. In Ayurveda this condition can be considered under *Nadi vrana.* In *Agadatantra* perspective hidradenitis suppurativa (HS) can be corelated with *Dushivisha*, a state where accumulated toxins disturb the body's equilibrium, leading to chronic suppurative conditions. The condition may arise due to prolonged dietary and life style errors that promote *Doshadushti* and *Srothorodha*. The inflammatory, suppurative nature of HS suggests *Pitha Kapha* dominance with vitiation of *Raktha Dhatu*. *Sodhana* like *Vamana* and *Virechana* may help in toxin removal. *Agada* like *Taruna bhaskaram Gulika* and *Triphala Guggulu, Gandhaka rasayana* are useful in detoxifying the blood.*Guggulu* may help in controlling microbial activity. *Kashayadhara* with *Patolamooladi Kashaya* may reduce inflammation and reduce pus also. *Parisheka* with *Kottamtakaradi kwatha* can aid in wound healing. *Tiktha Katu Rasa* predominant internal medications like *Triphala Guggulu* and *Gandhaka Rasayana* may help in chronic pus formation.

CONCLUSION

In *Agadatantra,* Hidradenitis Suppurativa (HS) can be approached through a combination of *Vishahara chikitsa*, *Rakthaprasadhana* and *Vrana ropana* measures. A holistic plan incorporating detoxification, herbal remedies and dietary regulations can help manage this condition effectively

Before Treatment

Fig 1

Fig 2

After Treatment

Fig 3

Fig 4

Fig 5

Fig 6

Fig 7

REFERENCES

1. Kurzen H, Kurokawa I, Jemec GB, et al. What causes hidradenitis suppurativa? Exp Dermatol. 2008; 17: 455–472.
2. Naldi L. Epidemiology. In: Jemec G, Revuz J, Leyden JJ, editors. Hidradenitis Suppurative. Berlin: Springer; 2006. pp. 58–64
3. Alikhan A, Lynch PJ, Eisen DB. Hidradenitis suppurativa: a comprehensive review. J Am Acad Dermatol. 2009; 60(4): 539–561.
4. Margesson LJ, Danby FW. Hidradenitis suppurativa. Best Pract Res Clin Obstet Gynaecol. 2014; 28: 1013–1027.5
5. Prens E, Deckers I. Pathophysiology of hidradenitis suppurativa: an update. J Am Acad Dermatol. 2015; 73(5 Suppl 1): S8–S11.
6. Jemec GB, Thomsen BM, Hansen U. The homogeneity of hidradenitis suppurativa lesions. A histological study of intra-individual variation. APMIS. 1997; 105: 378–383.
7. Kamp S, Fiehn AM, Stenderup K, et al. Hidradenitis suppurativa: a disease of the absent sebaceous gland? Sebaceous gland number and volume are significantly reduced in uninvolved hair follicles from patients with hidradenitis suppurativa. Br J Dermatol. 2011; 164(5): 1017–1022.
8. Yu CC, Cook MG. Hidradenitis suppurativa: a disease of follicular epithelium, rather than apocrine glands. Br J Dermatol. 1990; 122: 763–769.
9. Jemec GB, Heidenheim M, Nielsen NH. The prevalence of hidradenitis suppurativa and its potential precursor lesions. J Am Acad Dermatol. 1996; 35: 191–194.
10. Esmann S, Jemec GB. Psychosocial impact of hidradenitis suppurativa: a qualitative study. Acta Derm Venereol. 2011; 91: 328–332.
11. Revuz J. Hidradenitis suppurativa. J Eur Acad Dermatol Venereol. 2009; 23(9): 985–998.

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